

TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, November 28, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

HIP-JOINT AMPUTATION FOR SARCOMA OF THE FEMUR.

DR. F. W. MURRAY presented a man, eighteen years of age, who was admitted into the New York Hospital in June, 1894, with an irregular, tender, hard growth, involving the lower third of the femur. The tibia was not involved. The inguinal glands were distinctly enlarged. The first symptom of pain and swelling had been noticed first but four months previously. When admitted, the patient was pale, weak, and thin, and complained of constant pain in the right knee and outer side of that leg and foot.

June 18, disarticulation at hip-joint was performed by the so-called "Wyeth method." Owing to a mistake on the part of the instrument-maker, the pins were only one-sixteenth inch in thickness, and bent after applying the tourniquet. This caused some difficulty in freeing the head of the bone, and one or two vessels in the posterior flap to spurt, otherwise the operation was eminently satisfactory. Very little blood was lost, and the shock was not more than would be expected considering the condition of the patient. Large rubber drainage-tube was introduced through outer angle of wound to the acetabulum, and flaps united by silk suture, sterilized dressing. Heat and stimulants applied after removal to the ward, and in a few hours patient had recovered in a great measure from shock. Some hours after operation temperature rose suddenly to 107° F., but it soon began to fall, and in twenty-four hours was about normal. This was, undoubtedly, an example of the so-called "fermentation fever," and had no deleterious effect on the patient.

The dressing was changed on the second day, and beyond a con-

siderable bloody discharge through the tube nothing was noted. Tube and stitches removed June 27, union *per primam*, excepting at site of tube, where there was an abundant serous discharge. The patient rapidly gained strength, and was soon up and around the ward, and beyond the existence of a sinus at the former site of drainage-tube the stump was in good condition. Early in August, as the sinus still existed and discharged a considerable amount of serous fluid, it was curetted thoroughly and packed with gauze. No improvement followed, and a second sinus appeared in the centre of the scar, on outer side of stump, a few weeks afterwards. August 24, under ether, the outer end of the stump was slit up, the sinuses dissected out, the acetabulum thoroughly curetted, and the wound was packed with iodoform gauze. For twenty-four hours after operation patient did well, when suddenly the temperature rose to 104.6° F. From this time until August 30 the temperature steadily increased until it was 106.8° F. on the latter date, when suddenly it dropped to normal. There was no appreciable increase in the pulse-rate and respiration accompanying this elevation of temperature, and repeated examination of the wound revealed nothing abnormal.

During this period the patient was intensely nervous and excited, and complained of such intense pain in the wound that chloroform had to be administered at each dressing. The wound healed rapidly, and to insure healing from the bottom a drainage-tube leading to the acetabulum was inserted.

His further history was uneventful. The stump is now entirely healed, excepting a small superficial granulating spot where tube was inserted. The general condition is excellent, the patient has gained thirty pounds since operation, and returns next week to work. It is almost six months since the operation. There are no signs of recurrence of the disease, and the enlarged inguinal glands have disappeared. At the operation the shaft of the femur was left intact, and not sawn through, so that the entire limb, used as a lever, facilitated the throwing out of the head of the bone from the acetabulum. The pathologist reported that the growth was a small, round, and spindle-cell sarcoma of the femur. It was limited to the bone, and had not affected the overlying soft parts.

DR. ABBE thought the "bloodless method" of Mr. Spence, of Edinburgh, for which Mr. Cheyne, in the "Edinburgh Hospital Reports for 1893," claims priority over Dr. Wyeth by ten years, and which consists in the use of one skewer and an elastic tourniquet, pos-

sesses some advantages. The skewer traverses the inner half of the thigh, the side on which are all the great vessels, and these are constricted by the elastic tourniquet, applied in figure-of-eight over the skewer ends, leaving the outer half of the thigh perfectly free to be dissected up in reaching the neck of the femur, and in manipulating the bone.

Dr. McCOSH said he had used Wyeth's skewers in a case some years ago, and had not found them at all in the way of the operation. Mattress needles, a quarter of an inch in diameter, were used. The operation was bloodless from the proximal side of the wound. There was some difficulty in getting out the head of the bone, because, owing to infiltration of the upper part of the shaft of the femur with sarcoma, it had become separated from the neck before the operation. The skewers did not interfere with the incisions. The muscles surrounding the stump were infiltrated, and large portions were excised, yet there was no recurrence in the stump. The patient died about a year later of multiple metastatic sarcomata, involving the lungs, scalp, lips, etc. Dr. McCosh thought the results in Dr. Murray's case were exceedingly satisfactory with regard to the appearance of the stump and freedom from return.

Dr. RUSHMORE said that in a case of malignant disease of the femur operated upon three or four years ago he had controlled hæmorrhage by the Jordan-Lloyd method, and it had proved very satisfactory. The patient was a man past seventy, a sufferer from chronic dyspepsia and chronic bronchitis, had had several attacks of hæmaturia, the disease had already fractured the bone. An attack of pneumonia necessitated the postponement of the operation, yet, except for moderate sloughing in the posterior flap, the patient made a very satisfactory recovery. There had been no return of the disease at the end of four months.

PERITONITIS IN THE MALE AS A COMPLICATION OF GONORRHOEA.

Dr. A. J. McCOSH read a paper with the above title. (See page 140.)

Dr. McCosh was asked what was the condition of the patient whose case was related in the paper just before the illness which caused him to be taken to the hospital, and also whether gonococci had been found.

DR. McCOSH replied that the history of the case for the date just referred to was somewhat obscure, although it seemed the man had claimed to be well until a few days prior to his admission to the hospital. Dr. Brown had not found gonococci in the urethra, nor had they been found in the peritoneum at the time of the operation. It is only within the last year or two that bacteriologists have been able to cultivate gonococci with any degree of success, and the failure in this case to find these bacteria in the medium which was inoculated by the peritoneal exudate is no positive evidence that they were not present. The man claimed that the urethritis was not specific, but probably he was mistaken, and apparently the peritonitis was a complication of gonorrhœa.

DR. HOTCHKISS mentioned a case which he thought was probably one of retroperitoneal cellulitis complicating a posterior urethritis. The man had been transferred to Bellevue from another city hospital. He had had deep urethral trouble. Subsequently deep retroperitoneal abscess developed. There were no signs of peritonitis,—all the symptoms were purely septic. After he had been in the hospital about thirty-six hours a peculiar emphysematous swelling appeared in the left groin below Poupart's ligament, which went on to extend upward in the line of the descending colon, with which it was supposed to be in communication, as it had gaseous contents. At the autopsy no communication with the bowel was found, and the conclusion was reached that the case was originally one of deep urethral inflammation, from which the infection had extended along the prostate and the subperitoneal tissue, the patient dying of sepsis in about forty-eight hours before invasion of the peritoneum itself had occurred.

Dr. Hotchkiss objected to the case of Dr. McCosh being classified as one of pure gonorrhœal peritonitis, since the microscope had shown it to be a case rather of septic peritonitis.

DR. ABBE thought the question suggested by Dr. Hotchkiss's remarks a very pertinent one,—viz., whether the peritonitis in the cases referred to was gonorrhœal or septic. It seemed that in the female peritonitis of this character occurred very often, much oftener than in the male, but it was also likely to be of different type, characterized by rapid formation of plastic lymph, which acted as a barrier against further extension, and made the case one of local peritonitis, thus differing from the inflammation in the cases quoted, which seemed more like ordinary septic peritonitis. It was an interesting

fact that in the acute arthritis or synovitis of gonorrhœa careful search revealed gonococci in the fluid the first few days, but after a week they could not be discovered, having been destroyed by the inflammatory phagocytes in the fluid. In the author's case he thought the weight of argument was in favor of a mixed infection rather than one of pure gonococcus.

DR. McCOSH rejoined, the case was certainly one of septic peritonitis, since streptococci and staphylococci were found. Failure to find gonococci at this stage might not be of much value, so that the question whether the case was one of mixed infection or one of gonorrhœal infection could not be decided. The question whether gonococci were capable of exciting septic peritonitis had not been fully settled. The evidence had been mainly negative. He believed the majority of pathologists were of opinion that the gonococcus could not excite peritonitis, but until that question was definitely decided he thought it would be hard to arrive at a just conclusion as to the source of the infection in cases of peritonitis complicating a specific urethritis. In his own case he thought death could be regarded as a result of the urethritis, and the chances were that the urethritis had been a specific one.

GASTROSTOMY BY WITZEL'S METHOD FOR CARCINOMA OF OESOPHAGUS.

DR. F. W. MURRAY related the case of a man, sixty years of age, who was admitted to the New York Hospital in September, 1894.

Nine months previous he had first noticed difficulty in swallowing. This increased steadily until three months ago, when he could only take liquid food. For four months he had had pain in the throat when lying down, and one week ago he brought up blood for the first time. He had lost forty-five pounds since last May, and when admitted was anæmic, thin, and poorly nourished. He could swallow but a tablespoonful of fluid at a time; was troubled considerably with regurgitation, and, at times, had attacks of coughing attended with pain. He was constantly hungry, and complained of his inability to swallow solid food. Tongue coated, breath very offensive. Moderate amount of emphysema and chronic bronchitis. Arteries rigid, marked cardiac hypertrophy. Urine contained albumen and few granular casts. An attempt to examine the œsophagus with bougies failed, as all instruments were arrested at a point six and a

half inches from the incisors. With the mirror a growth could be detected at the beginning of the œsophagus, and on introducing the finger into the pharynx a mass could be felt. It was evidently a carcinoma affecting the upper end of the œsophagus. During the following ten weeks three attempts were made to pass bougies beyond the obstruction, but always with no success. The dysphagia gradually grew worse and at times was complete, so that feeding per rectum was resorted to.

September 29 gastrostomy was performed by the Witzel method. The stomach was easily drawn into the wound, and the operation presented no difficulties whatever. The patient reacted well, and on the next day feeding was commenced through the tube. For the first two days nourishment was given by the tube and the rectum alternately every three hours. From the third day on he was fed solely through the tube, and digested his food easily. Nourishment consisted of peptonized milk, soups, raw eggs, and whiskey. The wound healed by primary union, and the stitches were removed on October 6. There was no leakage whatever, no eczema of the skin, and the dressing above the tube was always dry. He gained strength steadily, soon lost the sense of hunger, and was discharged, October 26, in good condition. Since he has left the hospital he has continued to gain, and at times he is able to swallow small amounts of finely-minced meat.